



# Shifting power in global health Decolonising discourses — Dialogue 2

Convened by



UNITED NATIONS  
UNIVERSITY

**UNU-IIGH**  
International Institute  
for Global Health



**DEVELOPMENT  
REIMAGINED**



**Wilton Park**

# SHIFTING POWER IN GLOBAL HEALTH

## Decolonising Discourses — Dialogue 2

**SUMMARY OF UNITED NATIONS UNIVERSITY, DEVELOPMENT  
REIMAGINED, AND WILTON PARK VIRTUAL DIALOGUE**  
TUESDAY 1 MARCH 2022 (0600-0800 GMT & 1400-1600 GMT)

### EXECUTIVE SUMMARY

This event is the second in a series of dialogues on "Shifting power in global health", convened by the United Nations University - International Institute for Global Health in partnership with Development Reimagined and Wilton Park. The first dialogue took place last year and raised a number of questions about what it means to decolonise global health. A summary of that dialogue can be found [here](#). This second virtual dialogue focused on South-South partnerships, and one of the key themes from Dialogue 1: the role of South-South collaboration. Panellists were invited to discuss three aspects of the theme: South-South partnerships and their power dynamics; South-North alliances; and the role of global funders in South-South collaborations.

The second dialogue followed the format of Dialogue 1. It was conducted twice to accommodate a range of time zones and ensure continued global debate on the ideas and visions of different groups for what a decolonised global health looks like, what it requires, and the opportunities and challenges likely to be encountered. Here follows a synthesis of Dialogue 2 (sessions A & B) and a summary of the key points of discussion.

This report summarises the points of discussion raised by the participants of the dialogue, and does not necessarily reflect the views of the rapporteur or the three host institutions.

#### Key points from the dialogue:

- Overcoming longstanding power imbalances between the global North and the global South requires a *mindset change* on the part of everyone involved as well as external changes in appearance
- Whether the dialogue is about South-South relationships, South-North relationships, or South-funder relationships, decolonising must be guided by principles. Commitment to equity, gender sensitivity, human rights and ethics, and social solidarity have to be at the heart of any action to decolonise global health. Additional

principles noted were trust, transparency, and reciprocity.

- Global health funders are important in shaping the distribution of power across the global health landscape and must avoid reinforcing historical inequities and power differentials with more explicit and direct funding towards establishing and strengthening South-South partnerships and more bottom-up power dynamics.
- Many dominant and mainstream global health actors are now engaged in the 'decolonising global health' conversation – but it is important that they recognise the long history of prior efforts to ensure more bottom-up approaches to health and development, and to shift power towards actors in LMICs. They should also not expect to lead the process of change but be willing to be the objects of change themselves in the process of creating truly equitable partnerships, even if it means "giving up" power.
- There is a risk that the decolonising global health movement will result in academic institutions of the global South replicating the problematic practices and behaviours of their counterparts in the global North. This can be mitigated by global South academic institutions actively seeking partnerships with social movements and communities. However, care needs to be taken to ensure that they value and learn from social movements and communities and not co-opt them.
- Academic publishing also has a role to play in helping to overcome longstanding power imbalances between the global North and global South. Whether reforms to academic publishing should take place within established publications or lead to a new group of key players remains up for debate.
- Although money is power, social movements wield power derived from other forms of capital – social, cultural, moral, and political amongst others – which can translate into financial pressure or influence.
- Although the terms "global South" and "global North" are useful terms for describing a major set of structural inequalities within global health, they can mask the South's complexity, ignore those at the periphery in the North, and create a false dichotomy that ignores the fact that important global power dynamics occur within a de-nationalised or supra-national space.
- The need for the health community to engage with power differentials across the broader global political economy was raised as a question. In the absence of doing so, there is the danger of the health community seeking to find equitable health sector partnerships within a wider unequal world.

The aim of the second dialogue was to create a space for open discussion and exploration of the opportunities to decolonise global health through South-South collaboration and partnerships. Through the various threads of conversation summarised above, a key point of intervention emerged: funding streams to support and strengthen South-South collaborations. The third dialogue in the "Shifting power in global health" series will focus on mechanisms that global South practitioners, academics, and advocates can implement to harness their agency over global health finance.

# INTRODUCTION

"Shifting power in global health" is a series of dialogues convened by the United Nations University - International Institute for Global Health, Development Reimagined, and Wilton Park. The series brings together diverse stakeholders – especially underrepresented voices – for an open and honest discussion about the future of the decolonising agenda in global health. Each dialogue in the series is hosted twice on the same day to maximise participation from different time zones. Under Wilton Park protocols, participants are invited to speak as individuals rather than representatives of their organisations. A safe space for an interactive and frank discussion is created through the assurance of non-attribution in reporting these sessions, as per [Wilton Park protocol](#).

The first dialogue generated a wide-ranging conversation with many questions, setting the scene for the second dialogue's exploration of the role of South-South collaboration and partnerships. A number of panellists were invited to discuss the following three aspects of the theme:

- South-South partnerships and their power dynamics: How do successful South-South partnerships manage power differences and imbalances within the global South? How do we promote South-South partnerships that are fair and mutually beneficial?
- South-North alliances: How can alliances or partnerships between people and organisations in the global North and people and organisations in the global South help overcome longstanding power imbalances between the global North and global South?
- Global funders and South-South collaboration: How can global health funders avoid reinforcing historical inequities and power differentials; and more explicitly direct funding towards establishing South-South partnerships and more bottom-up power dynamics?

The aim of this dialogue was to create a space for open discussion and exploration of the opportunities to decolonise global health through South-South collaboration and partnerships.

Each session comprised a set of panellist interventions in plenary followed by a discussion and one breakout group discussion with feedback. The dialogue provided eight plenary presentations, feedback from five groups, and plenary discussions. Participants were also able to provide comments via the meeting chat function. This report combines both sessions, presenting the key themes that emerged from participants' contributions, thoughts, and opinions.

Consistent themes emerged in both sessions, such as the need for a complete mindset change towards understandings of health, the need to look beyond single-issue areas, and the need to learn from the past to avoid the risk of perpetuating history and creating new forms of colonialism. The importance of principles as a critical part of collaborative relationships and the role of social movements were also repeatedly emphasised.

## KEY THEMES

“ .....  
Any kind of change is complex, and this one is possibly more complex than many other endeavours. Change is never easy. We need to be mindful that there are no silver bullets and magic solutions. (1)  
..... ”

### 1. Mindset change is as important as changes in appearances

Overcoming longstanding power imbalances between the global North and the global South requires a *mindset change* on the part of everyone involved as well as external changes in appearances. Among the points raised by the dialogue participants were:

- Decolonising global health will require the decolonisation of minds as well as structures, partnerships, and decision-making. The current understanding of health, fixed by a biomedical techno-managerial focus, permeates both the global North and the global South, due in part to many being educated in the global North. (2) Whether a person is in the North or the South, they may have a colonised mind – an understanding of health that is biomedical techno-managerial.
- There is a plurality in health, health systems, and health traditions, yet academics, researchers, and others still think of health in a limited monolithic way. Decolonising the minds of academics, policymakers, funders, and others will require a paradigm shift that celebrates this plurality. For example, in global health forums, there is now a growing appreciation of the need to integrate ecological, material, and psychosocial dimensions of well-being and principles of equity, reciprocity, and collective security as a basis for well-being.
- The ‘supremacy’ mindset held by many high-income countries in the North must be challenged. Historically, countries that are now high-income have exploited the global South to achieve this status, while low-income countries remain as such because of what has been stolen for four centuries. This mindset that governs the power dynamics of regional and global interactions must be challenged.
- Changing mindsets starts with education, including education in the global South. Global South education institutions need to stop looking to Northern curricula and norms, develop curricula to suit their local contexts, and “stop being ventriloquists”. “Everything needs to be revisited—focus on the needs of the South, the health of the population and the education of our children based on what we need”.
- Perhaps there is also a need to change the approach to different issues. When thinking about styles of communication and culture, it is imperative to reexamine the

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1 Where pronouns such as “we”, “us” and “they” appear in the summary of contributions, the pronouns reflect the comments of the contributors and are not referring to the convenors of the dialogue.

2 Global Health 50/50. [The Global Health 50/50 Report 2020: Power, Privilege and Priorities](#). London, UK, 2020. 85% of global organisations active in health and health policy have headquarters in Europe and North America, with two-thirds headquartered in just three countries: Switzerland, UK and USA.

- general appreciation of assertiveness in global health leadership through the lens of cultural differences. Some participants noted that cultural differences in leadership approaches, varying from brash and assertive to patient and polite, can have an impact on how power is balanced across different global actors. For those who acknowledge the power they hold, questions around next steps abound. How can those who hold power engage with these discussions in a productive manner? Should self-reflection lead to self-sacrifice in the form of stepping away from power? Or is there strength in numbers and therefore value in retaining power but using it as a collective for change? Ultimately, what is effective in advancing this movement as holders of power within an inequitable system?
- Questions about the individual feed into larger discussions of the collective. If decolonising global health is to be a movement, rather than a policy or structure, it will require the continuous pressure of “global health solidarity from below” to ensure that discussions amongst academics progress to actions taken with those at the heart of the struggle. Failing to do so will relegate this movement into a horizontal shift between two points of power rather than a vertical shift as a redistribution of power.
- The need to change mindsets extends to funders as well. By moving away from limited and short-term grant cycles, global health funders can avoid reinforcing historical inequities and power differentials. For example, it requires a significant change in mindset to think of a long-term vision that stretches beyond grant cycles to look at the next 10 to 20 years. Some funders have achieved such a mindset change, such as *Alliance for Accelerating Excellence in Science in Africa*.
- Finally, a mindset change will also require a shift away from operational and procedural issues to address deeper critical issues such as the international tax system and intellectual property laws. Addressing such critical issues will lead to the changes required to produce collective well-being and equitable partnerships.

“ .....  
 We need to actively examine our conscious and unconscious biases that make this unjust, inequitable partnership the acceptable norm.  
 ..... ”

## 2. Partnerships and principles

Whether it is about South-South relationships, South-North relationships, or South-funder relationships, decolonising must be guided by principles. Commitment to equity, gender sensitivity, human rights and ethics, and social solidarity have to be at the heart of any action to decolonise global health.

- Equitable partnership goes beyond how much money each partner receives and what they do. It is about critical principles observed when working together, such as trust, transparency, and reciprocity. These principles can encourage different viewpoints, balanced decision-making, and shared benefits. Additionally, the principles of openness, respect, accountability to each other and other stakeholders, and joint

learning and planning promote fair and mutually beneficial partnerships. Equitable partnerships are about the principles brought to the table and how well the partners work together.

- Global health funders are important in shaping the distribution of power across the global health landscape and must avoid reinforcing historical inequities and power differentials with more explicit and direct funding towards establishing and strengthening South-South partnerships and more bottom-up power dynamics.
- Three points should be at the centre of any funding model and are equally relevant to North-South and South-South partnerships:
  - First, all partners must recognise that equitable partnerships are not just a moral imperative but essential to achieve greater research impact and effectively tackle development challenges. Multi-disciplinary, locally aligned research, based on co-design and mutual benefit, has a much greater impact. Global research widens the talent pool, and it gains much more attention than national research. For example, from the United Kingdom, international outputs represent about 60% of publications, and garner much higher citation levels.
  - Secondly, partnerships must be built on mutual respect, trust, participation, and benefit to be truly equitable. There are many examples of how prioritising such partnerships has transformed the impact of global research. (3) There have been many efforts to set principles and guidance on how to form equitable research partnerships, including the San Code of Research Ethics, (4) the Commission for Research Partnerships with Developing Countries (KFPE) Guide for Transboundary Research Partnerships, (5) the Research Fairness Initiative, (6) and the UK Collaborative on Development Research (UKCDR) on the role of funders and equitable partnerships. (7) But there is always a gap between rhetoric and practice. For partnerships to be fully equitable, the move from principles to practice must centre global voices that have the contextual and cultural knowledge and insight to drive real change.
  - Thirdly, it is important to recognise that in establishing equitable partnerships, there are many tradeoffs. Partnerships need to build on trust, and this is a long-term process – it requires time and structural incentives at the funder or institutional level.
- A proposed tangible takeaway was to share case study examples of equitable partnerships, be they South-South or South-North, as well as examples of where actions to rebalance power haven't worked.
- An initiative in the Greater Mekong Sub-region (GMS) was raised as a potential case study in equitable partnership. (8) GMS countries have organised to develop a regional health cooperation strategy, with the Asian Development Bank (ADB) serving as the Secretariat. Regular meetings are conducted, and relevant plans respond to

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3 Elrha, [Research for Health in Humanitarian Crises](#) (2019). The review found that collaboration and partnerships, including with people affected by the crisis, improved the quality, impact and uptake of research and innovation.

4 [The San Code of Research Ethics](#).

5 Commission for Research Partnerships with Developing Countries, KFPE Guide - [11 Principles & 7 Questions](#).

6 [Research Fairness Initiative](#).

7 UKCDR, [Finding and building effective and equitable research collaborations or partnerships: The role of funders in equitable and effective international development research collaborations](#).

8 [Greater Mekong Subregion Health Security Project](#).

- local needs. The ADB views this type of collaboration as the way forward for South-South collaboration, as it simplifies funding and provides a mechanism to fund directly. It is a model that could be replicated in other regions.
- Linked to equitable partnerships and strengthening research institutions in the South is the need to ensure that experts in the South determine the topic of research and the programme to be implemented in their country, and not have it dictated or influenced by the fact that the funding comes from the North. Researchers in the South have more knowledge of the context and local challenges. Participants recalled an incident in which a large sum of funding was given by the US Presidential Malaria Initiative to a consortium of seven members, none of whom came from Africa, for a programme meant to be implemented in Africa. This paternalistic view ignores the expertise of the South and the need to co-create from an equal position which recognises, incorporates, and values Southern expertise. In the process of co-creation, the North and the South must be treated equally - “Don’t underpay one and overpay the others. This has a name: it is slavery”.
- Contrasting approaches to the use and provision of development assistance between China and Australia were described as illustrations of different approaches by donors. One example was of the former requesting a form of development assistance from Australia that was tailored to the needs of China, rather than accepting a form of development assistance that had been determined by Australia. Another example was of China declining a request from Australia to co-finance a Papua New Guinea development project that had been designed by Australia in favour of a more direct request from Papua New Guinea for assistance.
- Some participants argued that there needs to be some understanding of what equitable partnership means in money terms. There was agreement with the statement “money is power” and that nothing will change while money flows from the North to the South. Although a radical shift in funding and money and the distribution of financial resources is required, social movements show that power can also drive money.

### 3. Social movements

Although money is power, social movements wield power derived from other forms of capital – social, cultural, moral, and political amongst others – which can translate into financial pressure or influence.

- Participants expressed concern about ‘over-financialising’ the discussion. While money is power, social movements show that power also drives money. For example, the Treatment Action Campaign (TAC) and some governments drove the dialogue on the Doha Declaration on the TRIPS Agreement and Public Health. That and the current discussion on the TRIPS waiver have gone beyond money flows to different forms of power. It is important not to lose these other forms of power in the discussion.
- Many of the emerging decolonising global health discussions are happening in academic circles, global health organisations, and, to a certain extent, within funding spaces. But social movements have been talking about the decolonising agenda for

- some time now, suggesting that global health is lagging behind in a movement that already has foundations and momentum. Where are these broader social movements, and how can those in global health ensure that efforts to decolonise institutions, research, education, and practice are aligned with the work of these long-time advocates of justice and equity?
- It is important to recognise that social movements are different from NGOs and civil society. Conversations about decolonising risk transferring the colonial mindset from North to South rather than transforming it. Communities at the very heart of the push to decolonise must be involved in the agenda to prevent this, and social movements tend to be well-connected with communities. Some in the global health community feel the community does not truly understand social movements yet, but it is imperative to the success of the decolonising agenda that we bridge this divide.

#### 4. The role of academia

Many dominant and mainstream global health actors are now engaged in the 'decolonising global health' conversation – but it is important that they recognise the long history of prior efforts to ensure more bottom-up approaches to health and development, and to shift power towards actors in LMICs. They should also not expect to lead the process of change but be willing to be the objects of change themselves in the process of creating truly equitable partnerships, even if it means "giving up" power.

- Why are academics late to the conversation? Participants suggested that the systems and structures of academia, such as the way academic performances are rated and the way evidence is understood, might have prevented them from joining the conversation earlier. Does this suggest that the system is fundamentally in need of change, and what might change look like? On a broader level, does academia have a role in this movement at all, and what should that role be?
- Participants considered how academia conceptualises evidence and the impact of this view on how academia engages with others. Health academia has been slow to embrace engagement, whereas social movements embraced it long ago. Two factors have influenced this. Firstly, social movements and community engagement are typically assessed qualitatively, and the hierarchy of evidence which ranks qualitative evidence below quantitative evidence influences how academia views social movements. Secondly, academics accustomed to biomedical paradigms of health struggle to embrace broader conceptions of 'evidence' within the decolonising movement, where facts and solutions are not as easily identifiable. Some participants linked these two factors to a larger problem within health academia: arrogance, which makes academia reluctant to listen to and learn from other disciplines.
- At the same time, not enough is being done to strengthen academic institutions in the South. The North-South power relationship exists partly because the North gets the best of the South, a phenomenon known as "brain drain". The North is able to court students from the South on the strength of institutional reputation, and subsequently entices them to stay with the promise of opportunities. Southern institutions need to build opportunities for students, researchers, and institutions to work together; hence,

the challenge is for academics in the South to work with each other and not just work with Northern institutions. Funding is a key component in this undertaking; funders such as the ADB might be able to offer support, and those in the South should also challenge their governments to engage more by funding health research.

“.....  
Are we talking about shifting power or taking power? Shifting power has something to do with “move over and let me have a seat at the table”, but it is still the same table. Taking power is making sure that those who don’t have power at the moment have the confidence and ability to change the system, inform that change with a different vision, and lead that change.  
.....”

There is a risk that the decolonising global health movement will result in academic institutions of the global South replicating the problematic practices and behaviours of their counterparts in the global North. This can be mitigated by global South academic institutions actively seeking partnerships with social movements and communities. However, care needs to be taken to ensure that they value and learn from social movements and communities and not co-opt them.

- Where two academic institutions are working together, bringing in other stakeholders from the respective contexts will build community partnerships and feed into South-South partnership sustainability. However, concern was expressed about bringing social movements into the academic system; in the past, academia has expressed interest in social movements only to study them, and not learn from them. Thus, a key question is: Can academia or the knowledge structures for producing and communicating knowledge serve to value and elevate social movements, and how can academia join social movements and be part of them rather than the other way around?
- Academic publishing also has a role to play in helping to overcome longstanding power imbalances between the global North and global South. Whether reforms to academic publishing should take place within established publications or lead to a new group of key players remains up for debate. Academic journals are starting to refuse articles where researchers from the study country are not included in the authorship. These types of authorship rules could be developed into more general practice.

## 5. Language

Although the terms “global South” and “global North” are useful terms for describing a major set of structural inequalities within global health, they can mask the South’s complexity, ignore those at the periphery in the North, and create a false dichotomy that ignores the fact that important global power dynamics occur within a de-nationalised or supra-national space.

- Understandings of terms such as “international” and “global” need to be reexamined, as many continue to think that these terms are only applicable when high-income or Northern countries are involved. The post-WW2 era of South-South collaboration ushered in by decolonisation challenges this assumption.
- Some participants expressed discomfort with the continued use of the word “South”, as it often serves as a homogenous descriptor which masks the complexities of the South. This loss of complexity can be dangerous when it obscures key drivers of the movement such as the wide variety of contexts and communities the movement is trying to serve and partner with.
- Despite concerns, the word “South”, although imprecise, is operational in manifesting the colonial implications. Its use does not impede saying there are many “souths”, including in global North countries.
- Global systems such as international tax regimes are not necessarily located in the global North or South, and should not be conflated with the global North. They occupy a transnational space, and people who are complicit in these systems come from both the global North and South. Is there a danger in creating a false dichotomy between North and South that takes attention away from a truly globalised system?
- This feeds into a broader idea of “peripheries of global capitalism” rather than the global South. There are peripheries in the North as well – communities marginalised for their race, ethnicity, and more. Inequality exists not only between countries but within them as well, as wealth is increasingly concentrated within elite circles and corporations to the disadvantage of the wider population.

## 6. Questioning the geopolitical system

“.....  
 It is important to recognise that various forms of power used in colonial domination continue to be present in neo-colonial capitalism—this is not historical. It is present today.  
 .....”

The need for the health community to engage with power differentials across the broader global political economy was raised as a question. In the absence of doing so, there is the danger of the health community seeking to find equitable health sector partnerships within a wider unequal world.

- Unless the health community engages with the broader political economy to address issues related to the (lack of a) tax system, unregulated private finance capital and the impact it has on financialising all aspects of society, and the structural problems inherent in the intellectual property regime, we will forever be trying to mitigate these much deeper structural wounds in the global commons. What is the health community’s role in speaking beyond the health sector and engaging with upstream structural determinants?
- Both South-South and South-North interactions need to engage and negotiate with the structural, institutional, and narrative forms of power that underlie these interactions to avoid introducing new forms of domination and oppression. For

example, in areas of structural power, it is vital to confront international tax systems and intellectual property systems that protect existing corporate and country wealth at the cost of the very vital public revenue needed to distribute innovation globally. Other forms of power in need of confrontation include architecture and rule systems that privilege some countries over others, as well as narratives that steer or limit thinking, such as avoiding the deeper structural determinants of health and limiting the discussion of chronic conditions to behavioural and lifestyle factors.

## 7. From rhetoric to action

In line with key themes from the first dialogue, this second dialogue reinforces the need for concrete actions to advance the agenda of decolonising global health. The summary report of the first dialogue identified three sites of actions and three imperatives for change. In treading familiar ground, this dialogue surfaced more nuanced approaches to the previously identified elements of change – again, the sites of action concern individuals, institutions, and structural change:

- There needs to be a conscious attempt to understand the structural, institutional, and discursive forms of power that must be confronted in both South-South and South-North relationships. They imply a range of ethical, institutional, practical, and procedural issues that shape how interests and differences are negotiated, where agendas are set and decisions are made, how policies and programmatic interventions can be shaped, and what commitments are made for sustained investment in local innovation as well as technical and cultural resources. These issues shape how equity and investment in institutional and social capacities between different partners can be ensured, how different forms of experience, knowledge, and labour are valued, and where voice and agency lie in the (re)presentation of co-created work.
- Visions for a decolonised future include: empowering countries by removing donor shackles, developing local leaders so they can forge the pathways for institutional and system reform, creating safe, neutral policy space for leaders to come together, and bringing together multiple stakeholders in and outside of government. When there are no magic bullets and solutions, focusing on the people, structures, and processes is what matters.
- Alliances need to be built and designed to change systems and structures. If the attempt is to take power from the powerful, it is often crucial for the disempowered to form alliances to take power. Current academic regimes that exist to reinforce power asymmetries must be replaced by new alliances where Southern-based academic institutions work in partnership with progressive academic institutions in the North to change the system and structures of academia.
- Although power dynamics are inevitable, there can be strategies to mitigate the power that comes with the distribution of resources. For example, the promotion of partnerships with a small co-investment or ensuring agency on both sides even though an imbalance in the relationship of the monetary resource is present.

- Increasingly, international funders recognise the value of South-South partnerships and create new and innovative funding programmes that foster closer ties between researchers in different regions of the world, but these are not extensive. In the context of increasing pressures on overseas development assistance budgets and current evaluation models, not only is there a need to reform the funding model but also to move away from over-reliance on international donor time-limited funding towards the mobilisation of domestic resources and investments by governments and research institutions in the global South to internationalise their organisations and promote the establishment of longer-term strategic partnerships that are not subject to project cycles.
- There is a need for international funders to engage more with Southern partners in the discussions around global health and partnerships. Often global funders engage Southern partners in terms of recipients of funding to carry out research or do other activities. Now is the time for Southern institutions to take an active role in the discussions to inform collaboration and not be just recipients of funding. Southern institutions need to be at the table, and have their voices heard. If this can be achieved, South-South collaborations will flourish, and the gap between the North and the South in terms of global health work will be bridged.
- The power of funding needs to be shifted to the South to design and develop regional funding pools where evaluation is not based on grant cycles but over longer periods. It will take initiative, drive, and boldness within funding organisations to do this. Funders need to work together and leverage each other's strengths and weaknesses. Global South funders should be engaged in these dialogues as well. GloPID-R (9) has recently established a low and middle-income country research funders group, which brings together funders from high-income countries and low- and middle-income countries to think about how to work together.
- In addition to moving forward with South-South collaboration, we need to build on existing Southern intuitions, for example the ASEAN Vaccine Self-Sufficiency Initiative discussions held in 2019. While COVID-19 delayed a lot of the work, the thinking behind the ASEAN initiative should be examined because it is an existing institution in the South made up of countries from the region, some of which are middle-income countries. It is a model that could be used in other regions of the world, and it is a model a development bank could support. Once the mechanism is in place – institutions and structures – it could strengthen South-South collaboration and bring that agenda to the Southern countries.
- Justice, redress, racism, and healing—these issues are more and more evident in global health. Calling them out has the potential to turn the page. If we radically think about the issues, we can radically transform our language, interpretation, translation, and practices, and in so doing create new partnerships based on this mutual recognition of the bonds of the colonised subjects in the global South and North. At the same time, it sheds light on the structural problems such as racism that are embedded in all countries.

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9 [Global Research Collaboration for Infectious Disease Preparedness.](#)

- Alternative accountability mechanisms can also provide a way forward. The series of alternative World Health Reports prepared by Global Health Watch provides an accountability mechanism. (10) We can also look to the past and draw on the People’s Health Movement archive on Health For All to learn what has worked and what has not.

## NEXT STEPS

“.....  
We cannot allow the politics of knowledge to say “ours is the dominant correct view and yours is historic, necessary, and local.” Celebrating the plurality of health approaches and traditions could be something that fertilises the imagination and provokes us.  
.....”

The first dialogue established that “decolonisation in global health is not a topic for which there is a single solution”. A situation as dynamic and complex as this requires continued conversation, debate, and exchange of ideas, especially as the global health landscape experiences significant changes in reaction to the events of recent years. However, it is also necessary to look beyond global health to find commonalities with other communities and movements. Having established that academia is late to the conversation, the onus is on us to catch up to and connect with those who are fighting for the same cause in different spaces and through different ways, expanding this conversation to embrace the plurality of decolonisation efforts.

The third dialogue in this series will attempt to engage with some of these broader perspectives by focusing on funding mechanisms, which are often determined by factors beyond the narrow confines of global health. It will seek to identify core principles for decolonisation that unify the wide variety of organisations and individuals in both the global North and South working towards decolonisation by highlighting existing connections and commonalities.

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10 [Global Health Watch](#) is a collaboration between public health experts, non-governmental organisations, civil society activists, community groups, health workers, and academics. Initiated by the People’s Health Movement, Global Equity Gauge Alliance, and Medact, it is a platform of resistance to neoliberal dominance in health.

# ACKNOWLEDGEMENTS

The organisers of "Shifting power in global health: Dialogue 2" wish to thank all provocateurs and participants for their contributions to this series. Thank you as well to the joint organising team comprised of personnel from the United Nations University's International Institute for Global Health, Development Reimagined, and Wilton Park for supporting this and future dialogues in the series.

This report was prepared by rapporteur Helen Potts, with additional writing contributions by Tiffany Nassiri-Ansari.

To learn more about "Shifting power in global health" and participate in future dialogues, please contact:

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**Suggested citation:** United Nations University - International Institute for Global Health, Development Reimagined, & Wilton Park (2022). "Shifting power in global health: Decolonising discourses - Dialogue 2". DOI: 10.37941/ENJU6210